



DEC 22 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Bureau of Policy Development
Office of Chronic Care and Insurance Policy
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Min-DeParle:

We are writing to **submit** for your review and approval an amendment to California's **Title XXI State Plan**. California is revising its state plan to increase the application reimbursement fee to \$50 per successful application. California also is amending its state plan to reflect its established practice of exempting from copayments Indian children enrolled in the Healthy Families program who use Indian Health Service funded clinics.

Application Assistance Fee

California's approved State Plan includes provisions in Section 5.1 for a \$25 per successful application reimbursement fee to reimburse a variety of community organizations, referred to as Enrolled Entities (EE), for outreach and assistance in applying to the Healthy Families program. EEs include schools, day care centers, community clinics, faith-based organizations, and local health departments. In California's initial plan, submitted in November 1997, the amount of \$50 per successful application for California's Healthy Families Program was proposed. However, the Managed Risk Medical Insurance Board (MRMIB) later reduced the fee to \$25 per successful application after adjusting it to reflect the fact that assistors would not be helping applicants with health plan selection.

The lessons learned by the State and HCFA's experience in the enrollment of Medi-Cal beneficiaries into managed care in Los Angeles indicates that participation of community based organizations in outreach and enrollment in the Healthy Families program is critical to our ability to provide health care coverage to uninsured children in California. Community organizations come into contact with our target families daily, have the trust of these families, understand and have experience working with the many different cultural groups in California, and have staff who speak the many different languages that are spoken in California. These community organizations fulfill a significant role in outreach and enrollment, one that cannot be performed by government.

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California has been *very* successfbl in **signing up** community organizations to participate in outreach and enrollment assistance. Over 2,200 organizations have signed up to participate, with **almost** 12,000 outreach workers. Several **community** organizations have been **extremely** successfbl in their outreach efforts, which **demonstrates that this ourreach** and enrollment **model** can have very **good results**. However, under the \$25 fee **many** of the organizations indicated that they could **not** participate since the 525 reimbursement **was not** enough money to **cover their costs**. **As** of the end of September 1998, **only** 485 of the 2,200 organizations were **actually** participating in the outreach and application assistance process.

In response to **lessons** learned **during the first monrhs** of program operation, California made **some adjustments** to our approach to outreach and enrollment. **Most** noteworthy of these efforts was the establishment of a **work** group charged with creating a **simplified application**. In, addition, we **increased** the **application** reimbursement fee to respond to concern **from** **community** organizations that \$25 did not cover their costs, Therefore, California is amending its state plan with an effective date of October 1, 1998, to increase the reimbursement rate to \$50 per successful application.

California is raising the **application reimbursement fee** in order to promote greater outreach and enrollment and to align the payment **with** the workload required to **assist families** with enrollment. Feedback from current **EES** indicates that; the \$25 reimbursement fee is **not** adequate to cover the costs **associated with** their outreach and enrollment activities, as **many** spend a total of 2-3 hours with a family. This **time estimate** includes the time associated with **conducting** outreach **activities** to identify children in **target populations**, **contacting the family in** person or **via** phone to evaluate and encourage their interest in the programs, **helping the family to** fill-in the application and include **necessary** documentation, and **following-up with the family to** verify that the **application was** mailed in and the children were successfully enrolled. In addition, **some** of the families contacted and helped are ultimately determined to be ineligible for either program.

The experiences of the Korean Health Education, Information and Referral (KHEIR), a community based organization in Los Angeles that has been **very successfbl** in assisting Korean families, illustrate that the \$25 application **reimbursement** fee is **inadequate reimbursement** for the multiple hours **community organizations** spend assisting families. KHEIR spends half an hour on the phone with families to screen and educate families about the Healthy Families and Medi-Cal programs. KHEIR then schedules an in-person appointment **with** the family to complete the application, which typically takes 1-1/2 to 2 hours. After the **applicarions** have been submitted, KHEIR often spends an hour assisting families on follow-up issues. For example, families often call KHEIR to request assisrance with any letters they receive **requesting** additional information. KHEIR often schedules second appointments with families in order to assist them **with** follow-up issues

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Although **not** all enrolled entities **may** offer the **same** level of comprehensive assistance that **KHEIR** does, it is **not** **unique** in its **finding** that **assistance** to families in applying for either program requires a greater investment of time **than** it is **reimbursed** for. **The Asian Pacific Policy and Planning Council** conducted a survey of twenty Asian and Pacific Islander community organizations in Los Angeles and Orange Counties and **found** that **they** spent an average of 1-2 hours to assist a monolingual family. The **Department of Health Services** has recently launched its **own** survey of enrolled entities throughout the **state** in order to better **understand** the **time** and **level of staffing** being used for application assistance activities. **This** information **will** be provided to HCFA by mid-January 1999.

The increase in the application reimbursement amount is **further justified** by the average cost of \$58 per person for a contractor to assist Medi-Cal recipients in selecting a health plan, **This** amount **covers** the cost for beneficiaries who attend a presentation at a contractor presentation site and make a plan choice at that time. However, EEs perform more extensive functions in that they: **must educate** families about the benefits of having health insurance in order to recruit families to apply. **They also must explain the differences** between the Healthy Families and Medi-Cal for Children programs and assist the families through the application process. Increasing the reimbursement fee **from** \$25 to \$50 provides a **more** commensurate compensation for the **time** and **effort** expended by EEs.

Aligning the payment with the application assistance workload **will** have the benefit of allowing community organizations to assist **more** families. For example, KHEIR helped 1,135 Healthy Families and Medi-Cal applicants successfully apply **from** the end of June through November 3, 1998, however; approximately 400 to 500 people **remain** on KHEIR's waiting list. **Ten** to twenty new families per day request KHEIR's assistance in applying to Healthy Families or Medi-Cal. KHEIR **hopes** to **eventually use** the increase in the application reimbursement fee to hire more outreach workers. In addition to enabling EEs to expand their assistance **efforts**, the increased reimbursement will make it **financially** feasible for new **community** organizations to make staff available to become outreach **workers** and increase **their** outreach to actively recruit uninsured children.

DHS and MRMIB recently **released** a revised, four-page application for the Healthy Families and Medi-Cal for Children programs. Although the revised application is shorter than the current application, **because** it shifts the burden of calculating income **away** from the applicants, EEs will still perform important functions needed to assist families in applying. In addition to **continuing** to conduct education and outreach under the revised application, EEs may still perform **income** calculations in order to pre-screen families for Healthy Families or Medi-Cal eligibility. EEs will then be **able** to tell applicants which **documentation** that they need to provide. If applicants do not receive this type of assistance from **an** EE, then they do not know which program that are most likely eligible for and may not submit critical Healthy Families enrollment

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information, such as the Healthy Families Supplement to the application, a premium check, and health plan selection. EEs also will continue to assist the family in completing the application.

Copayments and Indian Health Service Funded Clinics

California's approved State Plan also includes provisions in Section 4.4.4 to assure the provision of child health assistance to targeted low-income children in the state who are Indians. Indian children enrolled in the Healthy Families program who use Indian Health Service funded clinics are not required to pay copayments for any services. At this time California is simply amending Section 4.4.4 to reflect this already established practice.

Enclosed with this letter you will find the applicable revised pages, the last paragraph on page 33 to the first paragraph of page 35 of Section 5.1— Outreach and Coordination, as well as pages 29 - 30 of Section 4.4.4 of California's Title XXI State Plan.

Sincerely,

S. Kimberly Belshe
Director
Department of Health Services

Sandra Shewry
Executive Director
Managed Risk Medical Insurance Board

Enclosures

cc: Sally K. Richardson
Claude Earl Fox, M.D.
Kathleen Farrell
Richard Chambers
Richard Fenton
Debbie Chang

While DHS will undertake the efforts outlined above, MRMIB will conduct a number of corresponding efforts to outreach to uninsured families whose children may be eligible for the insurance program. MRMIB will begin by starting a pre-enrollment process. From now until the program begins, MRMIB will be keeping a list of all potential beneficiaries who contact them expressing interest about the program. When all enrollment materials become available, MRMIB will mail enrollment materials to all applicants on their mailing list.

In addition to pre-enrollment, MRMIB may also provide a \$50 one-time application assistance fee for entities and individuals that assist beneficiaries applying for the Healthy Families program. MRMIB successfully uses an application assistance fee in two of its existing programs, MRMIIP and ADM. The purpose of the fee is to provide an outcomes based financial incentive to organization/person who come into regular contact with the target population. Use of the application assistance fee is particularly important as it is the way by which MRMIB creates an incentive for to encourage participation from a large number of community organizations who have contact with uninsured children. ~~insurance agents and brokers to participate in enrollment outreach. Agents and brokers are the primary means by which coverage is sold to small employers for whom most of the uninsured work. Traditionally, insurers pay commissions of 6-10% on a monthly basis for agent broker assistance. Use of a one time flat fee is a cost effective way to involve agents and brokers in outreach for the program.~~

MRMIB will pay the application assistance fee only for those beneficiaries who are successfully enrolled into the insurance program. Such entities, which are ~~have yet to be~~ certified by MRMIB, are broadly defined as groups which have potential outreach capabilities to educate and enroll targeted applicants into the Healthy Families program. They include, but are not limited to, Parent Teacher Associations, insurance agents and brokers, WIC clinics, community clinics, and county welfare departments. MRMIB certifies entities and individuals who are able to collect the application assistance fee, to ensure proper oversight of the efforts and avoid potential marketing abuses associated with the fee. Providing a \$50 assistance fee will give entities an incentive to inform, educate, and help enroll all potential beneficiaries.

In creating the Healthy Families state plan, the state is making an extensive effort to reach out to and receive input from the public. Comments and suggestions made by various public agencies have helped California to develop and shape its outreach strategies. The Health and Welfare Agency hosted two forums in October to receive input from the public on implementation of the Healthy Families program. In addition to the open forums, DHS conducted a series of meetings with stakeholder groups to obtain input on Healthy Families outreach efforts. The groups included community-based organizations: counties, program agencies, advocates, health plans, and providers. These meetings have helped create an Open dialogue between interested parties on this important issue of mutual concern.

In a similar vein, MRMIB holds bi-monthly public meetings to solicit public input in its decision-making process for Healthy Families, and will use a 14 member Advisory Board to receive further

constructive feedback. MRMB mails out drafts of regulations and model contracts to its extensive mailing list and solicits public testimony on the drafts prior to finalizing them. ~~Among the areas on which it is currently soliciting public feedback is what entities should~~ Page 34
continued ~~be eligible to receive the \$50 application assistance fee described above, should MRMB vote to approve the use of the fee.~~ Throughout the implementation process, DHS and MRMB will continue communication with interested groups to solicit feedback pertaining to California's outreach efforts.

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

The provision of child health assistance to low income children who are American Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c) (Section 2102)(b)(3)(D), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.
- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.
- Targeted statewide outreach media campaign and outreach activities through contracts with selected community based organizations providing services to American Indian children to assure that American Indian families are aware of the program throughout the state and to assist children in enrolling in the **Healthy Families** Program.
- Provision of training to local American Indian clinic staff for outreach and referral to the **Healthy Families** program.
- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi-Cal or **Healthy Families**.
- Indian children enrolled in the **Healthy Families** program will not pay copayments for any services received from Indian Health Service funded clinics.